



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

TRUCK INSURANCE EXCHANGE

Carrier's Austin Representative Box

Box Number 14

MFDR Tracking Number

M4-06-2057-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are two copies of additional documentation relevant to this fee dispute. Also enclosed are two copies of EOB's from other carriers, which show a higher rate of reimbursement, consistent to our usual and customary. We are requesting that our claims be paid at usual and customary."

Amount in Dispute: \$32,508.83

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with the statutory standards for reimbursement at section 413.011 of the Act, Carrier reimbursed Provider \$5,688.33 as fair and reasonable reimbursement... Provider has simply not met its burden of proof under rule 133.307(g)(3)(D) to establish that reimbursement of \$38,197.16 meets the statutory standards under the Act for reimbursement of outpatient facility charges for the procedure performed in this case. On the contrary, this amount is grossly excessive... Therefore, Provider is not entitled to additional reimbursement."

Response Submitted by: Stone Loughlin & Swanson, LLP, One Northpointe Centre, 6836 Austin Center Blvd., Suite 280, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2005 to April 28, 2005	Inpatient Hospital Services	\$32,508.83	\$357.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, Volume 16 *Texas Register*, page 2830, sets out the procedures for resolving medical fee disputes.
2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, Volume 22 *Texas Register*, page 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 21, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 2, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a “STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS,” dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers’ compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor’s estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer’s behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. This request for medical fee dispute resolution was received by the Division on November 21, 2005.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment.

Findings

1. The Division’s former rule at 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, Volume 22 *Texas Register*, page 6264, defines inpatient services as “Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital.” Review of the submitted documentation finds that the length of stay exceeded 23 hours. The Division therefore concludes that the services in dispute are inpatient services.
2. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, effective August 1, 1997, Volume 22 *Texas Register*, page 6264. Review of the submitted documentation finds that the length of stay was 1 day. The type of admission is surgical; therefore, the standard surgical per diem amount of \$1,118.00 multiplied by the length of stay of 1 day yields a reimbursement amount of \$1,118.00. This amount is recommended.
3. Per former Division rule at 28 TAC §134.401(c)(4)(A)(i), implantables (revenue codes 275, 276, and 278) shall be reimbursed at cost to the hospital plus 10%. Review of the submitted records finds that the health care provider billed revenue code 278 for 3 units. Review of the submitted invoices supports a cost to the hospital of \$4,400 for one unit of IMP GRAFT TENDON ALLOGRAFT, and \$79.50 for 2 units of IMP SCREW SYNTHES (at \$39.75 each) for a total cost of \$4,479.50 for the submitted implantables. Ten percent of this amount is \$447.95. The total recommended reimbursement amount for the submitted implantables is \$4,927.45.
4. The total recommended payment for the services in dispute is \$6,045.45. This amount, less the amount previously paid by the insurance carrier of \$5,688.33, leaves an amount due to the requestor of \$357.12.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$357.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$357.12 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	April 13, 2012 Date
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Signature	Medical Fee Dispute Resolution Manager	Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.